# JOB AID
# Provider Adjustments, Time Limit Overrides, and Medicare Overrides

## OVERVIEW

This Job Aid provides instructions on when and how to use the Medicaid Resolution Inquiry Form and the Medicaid Claim Adjustment Request Form. Additional information on the following types of requests is detailed in this Job Aid: review of a previously paid or denied claim, claim replacement or void, time limit overrides, and Medicare and/or Third Party Liability (TPL) overrides.

## MEDICARE OVERRIDES AND TIME LIMIT OVERRIDES

### Medicaid Resolution Inquiry Form

The **Medicaid Resolution Inquiry Form** is used to submit Medicaid claims for Medicare overrides and time limit overrides. Medicaid secondary claims (includes Medicare, Medicare Advantage part C, and third-party commercial insurance) must be submitted within 180 days from the primary insurer's Explanation of Benefits (EOB) date, regardless of the service date on the claim or whether the claim was paid or denied.

When submitting inquiries, always use the **Medicaid Resolution Inquiry Form** located on the NCTracks public Providers page. Overrides will not be issued on claims without this form. Each inquiry requires a separate form and copies of documentation (EOB, vouchers, and attachments). Since these documents are scanned, attach only single-sided documents to the inquiry. **Do not attach double-sided documents to the inquiry.**

**Note:** The NCTracks interactive Claim Submission system supplies a secure access, browser-based application for providers to submit claims transactions to the system. This is the most efficient form of submission.

To access the form:

1. Navigate to the NCTracks public Providers home page: https://www.nctracks.nc.gov/content/public/providers.html
2. Select the Provider Policies, Manuals, Guidelines and Forms hyperlink on the left side of the page.

3. Go to the **Provider Forms** section at the bottom of the page.
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- Office Administrator (OA) Change Process
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5. Complete and upload the form or mail the form to CSRA at the address specified on the form.

**Note**: When submitting inquiry requests, always attach the claim, a copy of any Remittance Advice (RA) documents related to the inquiry request, and any other information related to the claim. Each inquiry request requires a separate form and copies of supporting documentation (EOB, vouchers, and attachments).

## Medicare Overrides and TPL

The time allowed to file a Medicare or third-party commercial insurance (including a Medicare Part C Advantage Plan insurer) request claim to Medicaid is 180 days from the Medicare or other third-party EOB date, regardless of the service date on the claim or whether the claim was paid or denied. The section of the Medicare or other third-party EOB showing the Claim Adjustment Reason Codes (CARCs) details must be submitted with the request. When a Medicare claim is denied because the service/procedure is non-covered, a Medicare override can be requested. Providing all of the "other payer" information, including the CARC details, on the electronic claim (see the Job Aid, *How to Indicate Other Payer Details or an Override on a Claim in NCTracks and Batch Submissions*) can provide this same override function in a more efficient manner than the paper form. Override requests for the denial of a covered Medicare or other third-party service are not acceptable and should be corrected and resubmitted to Medicare.

## Time Limit Overrides

All Medicaid claims (except hospital inpatient and nursing facility claims) must be received by NCTracks within 365 days of the date of service (DOS) in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last DOS** on the claim. If a claim was filed within the 365-day time period, providers have 18 months from the ***last*** RA date to refile the claim**.**

Requests for overrides must document that the original claim was submitted within the 365-day time limit. If the claim meets the 365-day time limit filing requirement, it can be resubmitted as a new day claim (no override required) if all of the following data is an exact match:

- Beneficiary/Recipient Identification Number (RID)
- National Provider Identifier (NPI)
- Service Dates
- Total Billed Amount

Claims that do not have an exact match to the original claim in the system will be denied and one of the following EOB codes will be displayed:

| EOB Code | Description |
|---|---|
| 00018 | Claim denied. No history to justify time limit override. |
| 01738 | Original transaction for rebill/reversal not posted as an NCPDP transaction |
| 05103 | Override request for timely filing is missing documentation |

When a claim is denied due to not having an exact match, if the time limit requirements have been met, the claim can be resubmitted via the NCTracks secure Provider Portal. The NCTracks Provider Portal will accept claims submission and appropriate documentation with a time limit override request indicated in the **Delay Reason** field. The Delay Reason Codes currently accepted in NCTracks are:

| Delay Reason Code | Description |
|---|---|
| 7 | Third-party processing delay |
| 9 | The original claim was rejected or denied due to a reason unrelated to the billing limitation rules |

**Note**: For all secondary insurance claims, regardless of the DOS on the claim, the provider has 180 days from the EOB adjudication date listed on the EOB from the primary insurance. The Medicaid Resolution Inquiry Form is no longer required if the claim requiring the time limit override is submitted electronically through the NCTracks Provider Portal or through a batch X12 transaction. For additional information, please read the NCTracks Medicaid Resolution Inquiry Form No Longer Required for Time Limit Overrides Announcement posted 02/03/2017.

The Division of Health Benefits (DHB) and NCTracks must adhere to all federal regulations to override the billing time limit; therefore, requests for time limit overrides must document that the original claim was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include the following.

- Dated correspondence from DHB or CSRA about the specific claim received that is within 365 days of the DOS.

- A primary insurance EOB dated within 180 days from the date of Medicaid claim submission.
- A copy of the RA showing that the claim is pending or denied; the denial must be for reasons other than time limit.

**Note**: The billing date on the claim or a copy of an office ledger is not acceptable documentation. The date that the claim was submitted does not verify that the claim was received within the 365-day time limit.

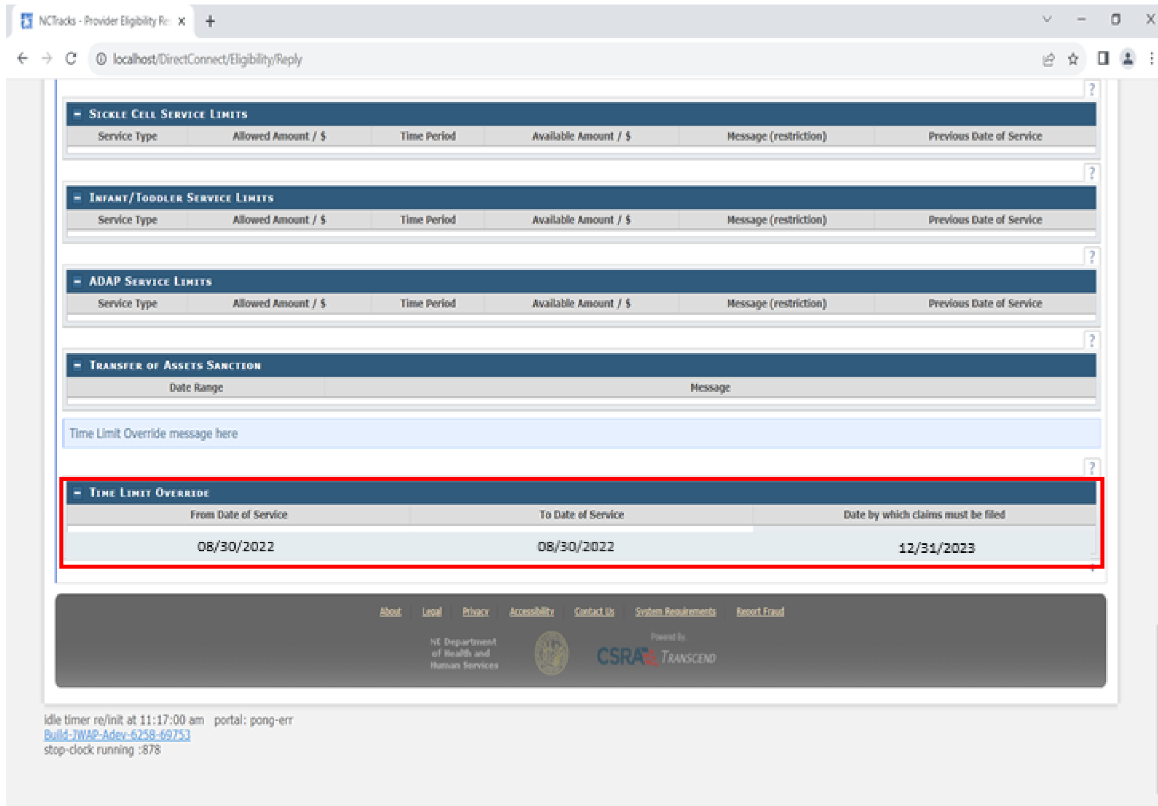
If the claim is a crossover from Medicare or another third-party commercial insurance (including a Medicare Part C Advantage Plan insurer), regardless of the DOS on the claim, the provider has 180 days from the EOB date listed on the EOB from that insurance (whether the claim was paid or denied) to file the claim to Medicaid. The claim should be submitted electronically, and a copy of the third-party or Medicare EOB can be uploaded as an attachment through the Provider Portal.

## Time Limit Override Spans Displayed on Provider Portal

When submitting time limit override claims, the Recipient Eligibility Response page of the Provider Portal displays up to three (3) active time limit override spans. If there are more than three active spans, an informational message to call the NC Medicaid Contact Center also displays.

To use this feature, the provider will enter recipient data on the Provider Eligibility Inquiry page including the Date of Service From and To values and select the **Check Eligibility** button. The Eligibility Response page will display with the time limit override spans shown in the **Time Limit Override** section at the bottom of the page. See the following image.

**Note**: The recipient's eligibility dates may not be consecutive if the approved time limit override has a range of dates with more than two dates of service. Contact the NC Medicaid Contact Center to verify specific time limit override dates.



**Note**: For additional information, please refer to the following documents:

- Instructor Led Training: *Submitting a Time Limit Override Request Using NCTracks*
- Participant User Guide: *Submitting an Institutional Claim*
- Participant User Guide: *Submitting a Professional Claim*
- Participant User Guide: Submitting a Dental Claim

## CLAIM ADJUSTMENTS

### Adjusting a Claim through the Void and Replacement Process

Submit claims electronically to adjust claim for an overpayment or underpayment. There are two separate actions that may be filed:

- **Void** – Entire claim will be recouped. Use the void action when the previously paid claim needs to be cancelled, recouped or refunded.
- **Replacement** – Entire claim will be recouped and reprocessed. Use the replacement action when the previously paid claim should be corrected. This term is interchangeable with adjusting a claim.

**Note**: In the NCTracks secure Provider Portal, the **Claim Information** tab has two fields that must contain accurate data to ensure the newly submitted claim will process as an adjustment:

- **Claim Frequency Type Code:** 7-Replace-PC or 8-Void-PC
- **Original Claim #:** Must contain the original claim number

For additional information, please refer to the Participant User Guide, *Claim Adjustments*.

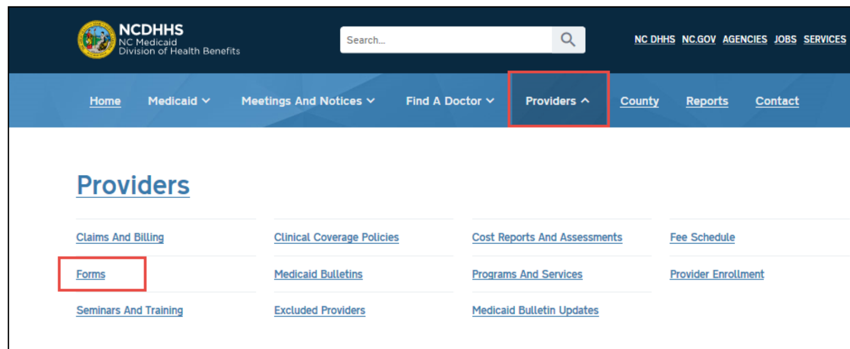
## Adjustments Related to TPL

If a primary insurance was not on file when the claim was processed or was on file but has ended and needs to be reported, the provider must notify DHB of other insurance.

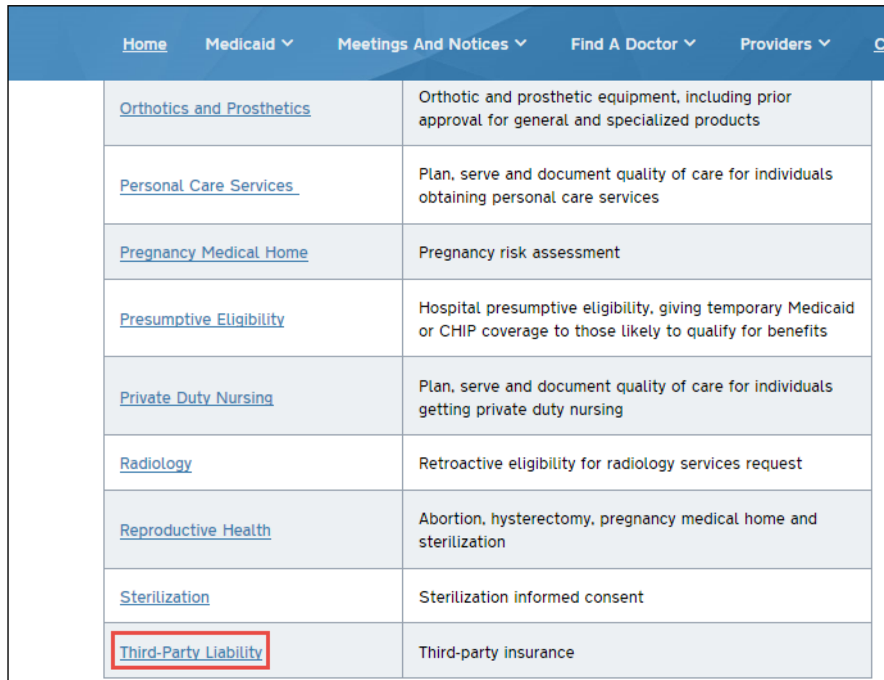
The provider shall complete and submit the 2057 referral form using the following steps:

**Note:** The online referral form is also used if the beneficiary no longer has insurance.

1. Navigate to the DHB website: https://medicaid.ncdhhs.gov/
2. Select the **Providers** hyperlink in the top navigation bar.
3. Select the **Forms** hyperlink.

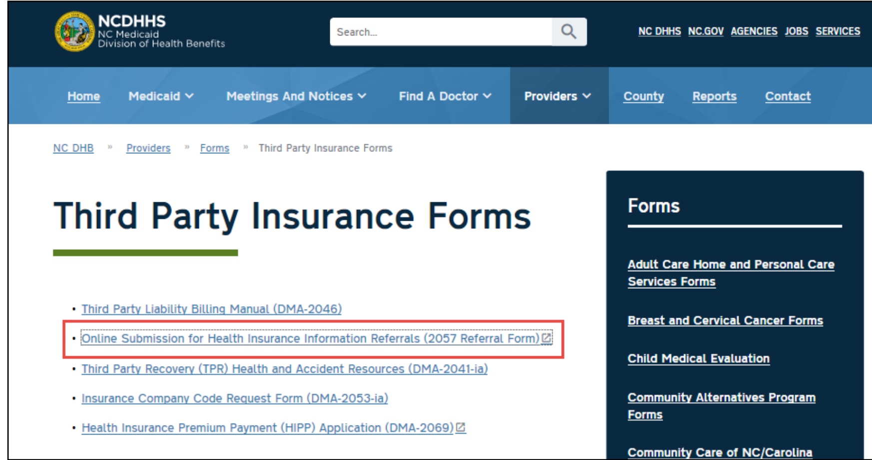



4. Select the **Third-Party Liability** hyperlink.



| Orthotics and Prosthetics | Orthotic and prosthetic equipment, including prior approval for general and specialized products |
|---|---|
| Personal Care Services | Plan, serve and document quality of care for individuals obtaining personal care services |
| Pregnancy Medical Home | Pregnancy risk assessment |
| Presumptive Eligibility | Hospital presumptive eligibility, giving temporary Medicaid or CHIP coverage to those likely to qualify for benefits |
| Private Duty Nursing | Plan, serve and document quality of care for individuals getting private duty nursing |
| Radiology | Retroactive eligibility for radiology services request |
| Reproductive Health | Abortion, hysterectomy, pregnancy medical home and sterilization |
| Sterilization | Sterilization informed consent |
| Third-Party Liability | Third-party insurance |

5. Select the Online Submission for Health Insurance Information Referrals hyperlink.




**Note**: Health Management System (HMS), the DHB TPL contractor, will update the beneficiary's record within 10 days of receipt of the 2057 Referral form. Once the beneficiary's TPL information has been updated, the claim can be resubmitted.

If Medicaid has paid the claim with the TPL amount deducted and subsequently the TPL carrier has changed the original paid amount, the provider should file an electronic replacement claim with the new TPL payment amount noted.

The CARCs and Claim Adjustment Group Codes (CAGCs) determine how NCTracks will react to TPL editing.

If a claim is denied by the prior payer, NCTracks will post the denial EOB 01843 – MEDICAID DENIED BASED ON CLAIM ADJUSTMENT REASON ASSIGNED BY PRIOR PAYER when the claim is submitted with prior payer CARC 97 reported at the claim header or detail line. The only exception will occur when a prior payer reports CARC 97 on the claim line with an Allowed Amount greater than zero.

**Important**: Providers must enter the CARCs and CAGCs on the claim exactly as they appear on the primary insurance EOB. Providers should NOT enter the codes at the header if they only apply to a single line on the claim.

For additional information, please refer to the Job Aid, *How to Indicate Other Payer Details or an Override on a Claim in NCTracks and Batch Submissions*.

## Medicaid Claim Adjustment Request Form

The claims adjustment process allows providers to request a review of a previously processed claim. Most claim updates can be submitted electronically; in some cases, an adjustment request must be submitted on paper.

The provider must submit an adjustment request using the **Medicaid Claim Adjustment Request Form**. For example, this form would be used if the provider receives the following EOB:

| EOB Code | Description |
|---|---|
| 00874 | Multiple ER visits not allowed same date of service, same taxonomy qualifier. File adjustment if visits were separate occasion. |

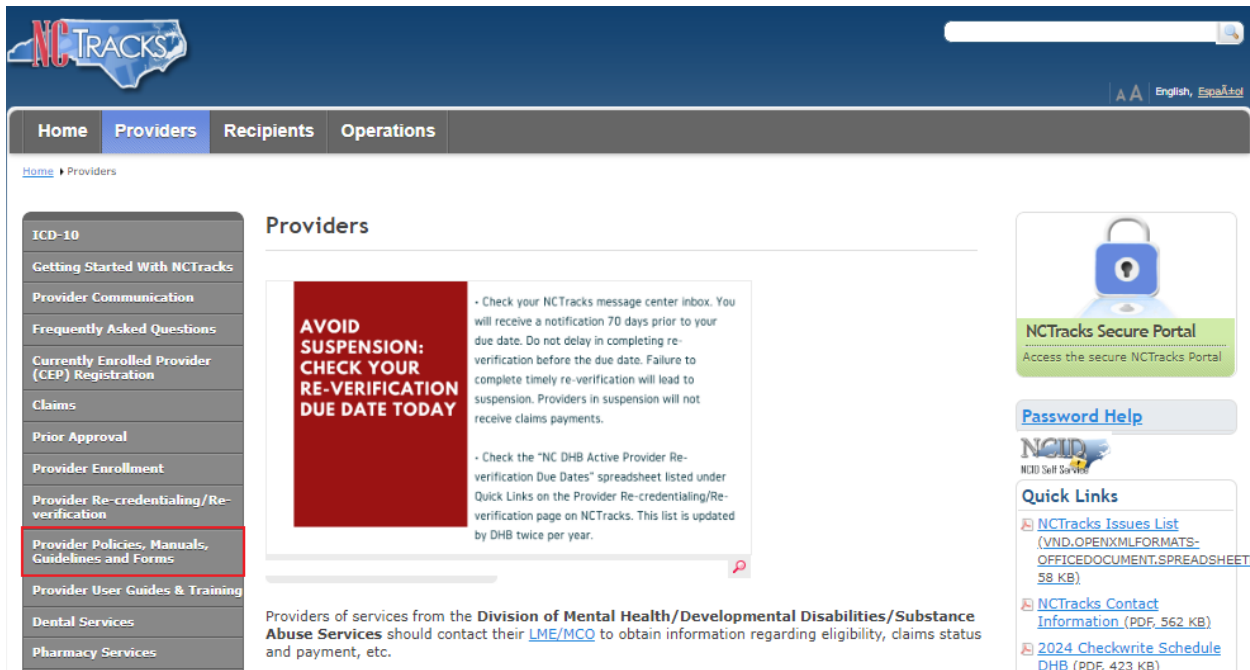
When requesting a Medicaid claim adjustment, please provide documentation of the medical necessity or extenuating circumstances that support the request for payment.

Please note that not all denials can be addressed through this process. Primary examples are non-adjustable EOB codes and CCI/MUE denials discussed later in this Job Aid.

If a claim has been denied with an EOB requesting medical records, the claim should not be submitted as an adjustment request on the adjustment request form. The claim should be resubmitted as a new day claim with the requested records.

To access the form:

1. Navigate to the NCTracks Provider Home page: https://www.nctracks.nc.gov/content/public/providers.html
2. Select the Provider Policies, Manuals, Guidelines and Forms hyperlink on the left side of the page.

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5. Complete and upload the form or mail the form to CSRA at the address specified on the form.

## Common Edits and How to Fix Them

The following EOB codes used by NC Medicaid are listed below with their suggested resolution(s). Although the suggested resolution(s) are for common denial cases, each claim may pose a unique processing scenario. Many edits cannot be overridden using the Adjustment form and instead would need to be corrected by fixing the claim and rebilling it. For further information, contact the NCTracks Contact Center for more claim-specific analysis/research.

| EOB Code | Description | Resolution |
|---|---|---|
| 08599 | The benefit plan is not matching provider or recipient eligibility or the service covered | The provider should verify that for the dates of service billed, the NPI is active for the Benefit Plan, the recipient is eligible for the Benefit Plan, and the Procedure Code is covered for that benefit. Submit a corrected claim if necessary. |
| 02310 | Procedure code is not covered or not on file for dates of service | Provider should refer to their Clinical Coverage Policy and fee schedule to ensure that the Procedure Code is covered for the dates of service billed. |

| EOB Code | Description | Resolution |
| --- | --- | --- |
| 04564 | System error from financial system | If DMH is the payer, the provider should ensure that all of the denied claims criteria are met per their Clinical Coverage Policy. For all other payers, the pended claims will continue to adjudicate once the budget issue is resolved. |
| 05203 | Service represented by this procedure code/modifier combination is not covered as billed. | Ensure that the Procedure Code and Modifier combination is covered by Medicaid. |
| 05400 | Exact duplicate-same rend prov/pcode/internal modifier/DOS/mod/bill amt/different TCN. | The provider should check paid history for the claim combination to ensure that the services are not paid in history for the same date of service, same procedure, same modifier, and same rendering provider. |
| 00024 | Procedure code, procedure/modifier combination or revenue code is missing, invalid or invalid for this bill type. Correct and rebill denied detail as a new claim | Provider can make corrections and resubmit the claim. |
| 01760 | Claim indicates Medicare is prior payer but no Medicare allowable amount is indicated for this detail. | Provider should verify Medicare payments are entered on claim lines appropriately as this EOB only post at the line level. Resubmit a corrected claim if necessary. If the claim was denied by Medicare due to billing issues, the provider should submit a corrected claim to Medicare. |
| 00079 | This service is not payable to your provider taxonomy in accordance with Medicaid guidelines | The claim will fail the edit if the procedure code or revenue code is invalid for the provider taxonomy billed.<br>Verify Claim Type assigned. Compare with the taxonomy and the Procedure Code or Revenue code billed to ensure the procedure code or revenue code is billable for that claim type and taxonomy code.<br>The provider should submit a corrected claim if necessary. |
| 02601 | Procedure not covered under the family planning waiver | The provider should verify the recipient's eligibility coverage and Procedure Code/Modifier combination. |
| 00167 | No charge billed. Enter billed amount and submit detail as a new claim | Providers should verify the Medicare paid amount and Medicare allowed amount and submit a corrected claim if necessary |

If you receive a denial EOB code with instructions on how to refile (example, bill with modifier 51), correct the claim as stated in the EOB and submit as a new claim.

## Correct Coding Initiative / Medically Unlikely Edits (CCI/MUE) Denials

The following three EOB codes indicate a claim that was denied for a CCI/MUE or other National Correct Coding Initiative (NCCI) edit. CCI/MUE denials cannot be adjusted.

| EOB Code | Description |
| --- | --- |
| 00585 | CLAIM DENIED. PROCEDURE CODE BILLED IS ON THE MEDICAL UNLIKELY EVENT TABLE FOR THE NCCI |
| 49270 | NCCI EDIT |
| 49280 | NCCI OUTPATIENT HOSPITAL SERVICES EDIT |

## Resubmission of Denied Claims

Claims that denied with a reason that can be corrected should be resubmitted as a new electronic claim.

When an adjustment request is denied, the provider will receive an EOB code on their RA stating the reason(s) for denial. A list of the EOB codes can be found in the EOB Codes and Descriptions section of this Job Aid.

Not all denials require an adjustment request. If adjustments are submitted for certain edits, the claim will be denied with one of the following EOBs:

| EOB Code | Description |
|---|---|
| 00998 | Claim does not require adjustment processing, resubmit claim with corrections as a new day claim. If POS, reverse and resubmit |
| 09600 | Adjustment denied. The EOB this claim previously denied with does not require adjusting. Correct/resubmit claim in lieu of adjustment request |

Resubmit a new or corrected claim instead of sending an adjustment request. Please contact the NCTracks Contact Center at 1-800-688-6696 if there are any questions on how to resolve a specific denial. Do not use the Medicaid Claim Adjustment Request Form to inquire about the status of a claim or to submit a claim for dates of service that have exceeded the filing time limit. Use the Medicaid Resolution Inquiry Form if you have exceeded the filing time limit.

## Pharmacy Claim Adjustments

The first choice of pharmacists is to reverse or edit pharmacy claims using their point-of-sale pharmacy program adjudicating claims through NCTracks. A **Pharmacy Adjustment Request Form** is available for providers to use to request an adjustment to a Medicaid payment when the adjustment cannot be processed online. This form is used to request an adjustment to a Medicaid payment for prescription drugs. Claims that are denied with no payment can be resubmitted instead of adjusted. Use the **Pharmacy Adjustment Request Form** to do the following:

- Credit Medicaid for a billed and paid prescription that was never dispensed
- Credit Medicaid for a billed and paid prescription for drugs that were unused
- Correct National Drug Code (NDC), quantity, days' supply, DOS, billed amount, Rx number, or third-party payment

The **Pharmacy Adjustment Request Form** can be found on the Provider Policies, Manuals, Guidelines and Forms page under **Provider Forms**.

## Reconsideration Review Requests

### *Appealing a Claim Denial or CCI/MUE Denial*

Providers can request a departmental claims review if an adjustment has been processed and denied. The department will consider the request and determine if the claim was denied incorrectly or if the provider can make corrections or present additional information. If the department determines the claim was denied correctly, a final notification denial letter will be issued. Providers may submit a letter requesting review of claims denial to DHB at the following address:

Division of Health Benefits
Appeals Unit
2501 Mail Service Center
Raleigh, NC 27699-2501

Preferred Option
Fax Number: 984-204-6792

### *Appealing Final Notification Denial Letter*

If a final notification is issued by the department, a provider may request a reconsideration review (appeal) within 30 calendar days from receipt of final notification denial letter. The appeal process requires documentation to support medical necessity for the service(s) being rendered in accordance with 10A NCAC 22J .0102.

If no request is received within the respective 30-day period, the Division's action shall become final.

Providers may submit a letter requesting reconsideration review of claim denials to DHB at the following address:

Department of Health and Human Services
Hearing Office
2501 Mail Service Center
Raleigh, NC 27699-2501

If you choose to submit documentation by fax, please limit the documents to 10 pages or less. You may attach as much documentation as you feel necessary via email or mail. Email submissions must be encrypted through the NCDHHS ZixMail portal. Providers may register at https://web1.zixmail.net/s/login?b=ncdhhs.

Fax Number: 919-882-1179

Email: Medicaid.Hearings@dhhs.nc.gov

**Before sending a letter requesting reconsideration from DHB, providers should determine if it is appropriate to rebill the claim using a modifier.**

## EOB CODES AND DESCRIPTIONS

The following are commonly used EOB codes and their descriptions.

| EOB Code | Description |
|---|---|
| 00014 | SERVICE DENIED PER MEDICAL CONSULTANT REVIEW |
| 00049 | MEDICAL NECESSITY IS NOT APPARENT |
| 00060 | NOT IN ACCORDANCE WITH MEDICAL POLICY GUIDELINES |
| 00074 | REIMBURSEMENT AMOUNT EXCEEDS SET DOLLAR AMOUNT |
| 00084 | RECIPIENT IS PARTIALLY INELIGIBLE FOR SERVICE DATES. RESUBMIT A NEW CLAIM BILLING ONLY ELIGIBLE DATES OF SERVICE |
| 00090 | DUPLICATE CHARGE DENIED |
| 00363 | NOT IN ACCORDANCE WITH MEDICAL POLICY GUIDELINES |
| 00382 | OPERATIVE RECORDS RECEIVED HAVE NO DATES OF SERVICE OR CONFLICTING DATES OF SERVICE, CORRECT CLAIM AND/OR RECORDS AND RESUBMIT BOTH AS AN ADJUSTMENT |
| 00394 | NOT IN ACCORDANCE WITH MEDICAL POLICY GUIDELINES |
| 00553 | TIMELY LIMIT EXCEEDED. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME |
| 00624 | DUPLICATE PROCEDURE. SERVICE ALREADY PAID FOR A DIFFERENT DATE OF SERVICE |
| 00716 | EXCEEDS ONE PER DAY LIMITATION |
| 00884 | REBILL ADJUSTMENT WITH RECORDS DOCUMENTING UNITS |
| 00893 | MEDICAL NECESSITY NOT APPARENT FOR CRITICAL CARE/PROLONGED SERVICES AND CONSULTS ON THE SAME DAY |
| 00896 | ADDITIONAL PROCEDURE, SAME DATE OF SERVICE, PAID AT 50 PERCENT OF ALLOWABLE AMOUNT |
| 00899 | UNITS CUTBACK. MAXIMUM NUMBER OF UNITS PER DAY EXCEEDED |
| 00901 | NO ADJUSTMENT DUE |
| 00959 | MAXIMUM NUMBER OF UNITS PER DAY PREVIOUSLY PAID FOR THIS DATE OF SERVICE |
| 01158 | ANTEPARTUM PACKAGE RECOUPED. TOTAL OB PACKAGE PAID WHICH INCLUDES ANTEPARTUM CARE |
| 01159 | TOTAL OB PACKAGE, WHICH INCLUDES ANTEPARTUM CARE, HAS ALREADY BEEN PAID FOR THIS GESTATION PERIOD |
| 00264 | ADJUSTMENT DENIED, CLAIM DENIED CORRECTLY |
| 00269 | BILL MEDICARE PART A CARRIER |
| 00271 | REFILE ADJUSTMENT WITH ALL RELATED MEDICARE VOUCHERS. RESUBMIT WITH NECESSARY INFORMATION ALONG WITH A COPY OF ORIGINAL CLAIMS RA |
| 00272 | ADJUSTMENT REQUEST DENIED, ADJUSTMENTS ARE NOT PROCESSED FO RATE CHANGES |
| 03120 | PREVIOUSLY BILLED PROCEDURE. SURGERY PERFORMED DURING FOLLOW UP OF ANOTHER SURGERY REQUIRES A MODIFIER. IF CURRENT CLAIM IS ORIGINAL PROCEDURE, REQUEST RECOUPMENT OF PAID DETAIL AND RESUBMIT WITH MODIFIER |